House Engrossed

State of Arizona
House of Representatives
Forty-eighth Legislature
Second Regular Session
2008

HOUSE BILL 2658

AN ACT

AMENDING SECTIONS 20-181, 20-182, 20-1380, 20-2301, 20-2304 AND 20-2309, ARIZONA REVISED STATUTES; RELATING TO INSURANCE CONTRACTS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-181, Arizona Revised Statutes, is amended to read:

20-181. Mandated health coverage; report to legislature

An organization, ~~or~~ individual OR LEGISLATOR advocating a legislative proposal which would mandate a health coverage or offering of a health coverage by an insurer, hospital, medical, dental or optometric service corporation, health care services organization or any other health care service contractor as a component of individual or group policies shall submit a report to the standing committee of the legislature that has been assigned to consider the proposal and the joint legislative budget committee before the committee OF THE WHOLE considers the proposal. The report shall assess both the social and financial impacts of such coverage, including the effectiveness of the treatment or service proposed, according to the factors prescribed in section 20-182. The legislature is not responsible for the cost of preparing the report, EXCEPT FOR A REPORT SUBMITTED BY A LEGISLATOR PURSUANT TO THIS SECTION.

Sec. 2. Section 20-182, Arizona Revised Statutes, is amended to read:

20-182. Factors for assessing impact; certification of report

A. To the extent that information is available, the report prescribed by section 20-181 shall include, but not be limited to, the following:

1. The social impact:

(a) The extent to which the treatment or service is generally utilized by a significant portion of the population.

(b) The extent to which the insurance coverage is already generally available.

(c) If coverage is not generally available, the extent to which the lack of coverage results in persons avoiding necessary health care treatments.

(d) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship to a patient.

(e) The level of public demand for the treatment or service.

(f) The level of public demand for insurance coverage of the treatment or service.

(g) The level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts.

2. The financial impact:

(a) The extent to which the coverage will increase or decrease the cost of the treatment or service.

(b) The extent to which the coverage will increase the appropriate use of the treatment or service.

(c) The extent to which the mandated treatment or service will be a substitute for a more expensive treatment or service.

(d) The extent to which the coverage will increase or decrease the administrative expenses of insurers and the premium and administrative expenses of policyholders.

(e) The impact of this coverage on the total cost of health care.

B. An actuary who is a member of the American academy of actuaries OR THE JOINT LEGISLATIVE BUDGET COMMITTEE shall prepare the financial impact analysis required by subsection A, paragraph 2 of this section and certify that the analysis is consistent with accepted actuarial techniques.

C. The report required by section 20-181 shall address the specific language of the proposed mandate. A report on a similar proposal in a different jurisdiction is insufficient and does not meet the requirements of section 20-181.

D. An organization, ~~or~~ individual OR LEGISLATOR that does not submit a report required by section 20-181 is not subject to any civil sanction or criminal penalty.

E. THE REPORT REQUIRED BY SECTION 20-181 SHALL BE SUBMITTED TO EACH MEMBER OF THE STANDING COMMITTEE TO WHICH THE LEGISLATION IS ASSIGNED.

Sec. 3. Section 20-1380, Arizona Revised Statutes, is amended to read:

20-1380. Guaranteed renewability of individual health coverage

A. Except as provided in this section, on request of the insured individual, a health care insurer that provides individual health coverage to the individual shall renew or continue that coverage.

B. A health care insurer may nonrenew or discontinue the health insurance coverage of an individual in the individual market only for one or more of the following reasons:

1. The individual has failed to pay premiums or contributions pursuant to the terms of the health insurance coverage or the health care insurer has not received premium payments in a timely manner.

2. The individual has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage.

3. The health care insurer has ceased to offer NEW coverage AND HAS DISCONTINUED ALL IN-FORCE COVERAGE in the individual market pursuant to subsection ~~C~~ D of this section.

4. If the health care insurer offers health care coverage through a network plan in this state, the individual no longer resides, lives or works in the service area or in an area served by the network plan for which the health care insurer is authorized to do business but only if the coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

5. If the health care insurer offers health coverage in the individual market only through one or more bona fide associations, the membership of an individual in the association has ceased but only if that coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

C. If a health care insurer decides to discontinue offering a particular policy form offered in the individual market, the health care insurer may discontinue that policy form only if:

1. The health care insurer provides notice to the director at least five business days before the health care insurer gives notice to each individual covered under that policy form of the intention to discontinue offering that policy form in this state.

2. The health care insurer provides notice to each individual who is covered by that policy form in the individual market at least ninety days before the date of the discontinuation of that policy form.

3. The health care insurer offers to each individual in the individual market whose coverage is discontinued pursuant to this subsection the option to purchase all other individual health insurance coverage currently offered by the health care insurer for individuals in that market.

4. In exercising the option to discontinue that type of coverage and in offering the option of coverage prescribed in paragraph 3 of this subsection, the health care insurer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for that coverage.

D. If a health care insurer elects to discontinue offering all health insurance coverage in the individual market in this state, the health care insurer may discontinue that coverage only if all of the following occur:

1. The health care insurer gives notice to the director at least five business days before the health care insurer gives notice to each individual of the intention to discontinue offering health insurance coverage in the individual market in this state.

2. The health care insurer provides notice to each individual of that discontinuation at least one hundred eighty days before the date of the expiration of that coverage.

3. The health care insurer discontinues all individual insurance or coverage that was issued or delivered for issuance in this state and does not renew any coverage that was offered or sold in this state.

E. If the health care insurer discontinues offering health insurance coverage pursuant to subsection D of this section, the health care insurer shall not issue any health insurance coverage in this state in the individual market for five years after the date that the last individual health insurance coverage was not renewed.

F. Subsection C of this section does not apply if the health care insurer modifies the health coverage at the time of renewal and that modification is otherwise consistent with this title and effective on a uniform basis among all individuals covered by that policy form.

G. A health care insurer shall provide the certification described in section 20-2310, subsection G if the individual:

1. Ceases to be covered under a policy offered by a health care insurer or otherwise becomes covered under a COBRA continuation provision.

2. Who was covered under a COBRA continuation provision ceases to be covered under the COBRA continuation provision.

3. Requests certification from the health care insurer within twenty-four months after the coverage under a policy offered by a health care insurer ceases.

H. The director may use independent contractor examiners pursuant to sections 20-148 and 20-159 to review the higher level of coverage and lower level of coverage policy forms offered by a health care insurer in compliance with this section and section 20-1379. All examination and examination related expenses shall be borne by the insurer and shall be paid by the insurance examiners' revolving fund pursuant to section 20-159.

Sec. 4. Section 20-2301, Arizona Revised Statutes, is amended to read:

20-2301. Definitions; late enrollee coverage

A. In this chapter, unless the context otherwise requires:

1. "Accountable health plan" means an entity that offers, issues or otherwise provides a health benefits plan and is approved by the director as an accountable health plan pursuant to section 20-2303.

2. "Affiliation period" means a period of two months, or three months for late enrollees, that under the terms of the health benefits plan offered by a health care services organization must expire before the health benefits plan becomes effective and in which the health care services organization is not required to provide health care services or benefits and cannot charge the participant or beneficiary a premium for any coverage during the period.

3. "Base premium rate" means, for each rating period, the lowest premium rate that could have been charged under a rating system by the accountable health plan to small employers for health benefits plans involving the same or similar coverage, family size and composition, and geographic area.

4. "Basic health benefit plan" means a plan that is developed by a committee established by the legislature and that is adopted by the director.

5. "Bona fide association" means, for a health benefits plan issued by an accountable health plan, an association that meets the requirements of section 20-2324.

6. "COBRA continuation provision" means:

(a) Section 4980B, except subsection (f)(1) as it relates to pediatric vaccines, of the internal revenue code of 1986.

(b) Title I, subtitle B, part 6, except section 609, of the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code sections 1001 through 1461).

(c) Title XXII of the public health service act.

(d) Any similar provision of the law of this state or any other state.

7. "Creditable coverage" means coverage solely for an individual, other than limited benefits coverage, under any of the following:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance~~,~~ OR reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A health benefits plan issued by an accountable health plan as defined in this section.

(d) Part A or part B of title XVIII of the social security act.

(e) Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.

(f) Title 10, chapter 55 of the United States Code.

(g) A medical care program of the Indian health service or of a tribal organization.

(h) A health benefits risk pool operated by any state of the United States.

(i) A health plan offered pursuant to title 5, chapter 89 of the United States Code.

(j) A public health plan as defined by federal law.

(k) A health benefit plan pursuant to section 5(e) of the peace corps act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through 2523).

(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

(m) A policy or contract issued by a health care insurer or an accountable health plan to a member of a bona fide association.

8. "Demographic characteristics" means objective factors an insurer considers in determining premium rates. Demographic characteristics do not include health status-related factors, industry or duration of coverage since issue.

9. "Different policy forms" means variations between policy forms offered by a health care insurer, including policy forms that have different cost sharing arrangements or different riders.

10. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct ~~analysis~~ ANALYSES of genes or chromosomes.

11. "Health benefits plan" means a hospital and medical service corporation policy or certificate, a health care services organization contract, A GROUP DISABILITY POLICY, A CERTIFICATE OF INSURANCE OF A GROUP DISABILITY POLICY THAT IS NOT ISSUED IN THIS STATE, a multiple employer welfare arrangement or any other arrangement under which health services or health benefits are provided to two or more individuals. Health benefits plan does not include the following:

(a) Accident only, dental only, vision only, disability income only or long-term care only insurance, fixed or hospital indemnity coverage, limited benefit coverage, specified disease coverage, credit coverage or Taft-Hartley trusts.

(b) Coverage that is issued as a supplement to liability insurance.

(c) Medicare supplemental insurance.

(d) Workers' compensation insurance.

(e) Automobile medical payment insurance.

12. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in an accountable health plan, including:

(a) Health status.

(b) Medical condition, including physical and mental illness.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.

(h) The existence of a physical or mental disability.

13. "Higher level of coverage" means a health benefits plan offered by an accountable health plan for which the actuarial value of the benefits under the coverage is at least fifteen per cent more than the actuarial value of the health benefits plan offered by the accountable health plan as a lower level of coverage in this state but not more than one hundred twenty per cent of a policy form weighted average.

14. "Index rate" means, as to a rating period, the arithmetic average of the applicable base premium rate and the highest premium rate that could have been charged under a rating system by the accountable health plan to small employers for a health benefits plan involving the same or similar coverage, family size and composition, and geographic area.

15. "Late enrollee" means an employee or dependent who requests enrollment in a health benefits plan after the initial enrollment period that is provided under the terms of the health benefits plan if the initial enrollment period is at least thirty-one days. An employee or dependent shall not be considered a late enrollee if:

(a) The person:

(i) At the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefits plan.

(ii) Lost coverage under a public or private health insurance policy or any other health benefits plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce or the termination of employer contributions toward the coverage.

(iii) Requests enrollment within thirty-one days after the termination of creditable coverage that is provided under a public or private health insurance or other health benefits plan.

(iv) Requests enrollment within thirty-one days after the date of marriage.

(b) The person is employed by an employer that offers multiple health benefits plans and the person elects a different plan during an open enrollment period.

(c) A court orders that coverage be provided for a spouse or minor child under a covered employee's health benefits plan and the person requests enrollment within thirty-one days after the court order is issued.

(d) The person becomes a dependent of a covered person through marriage, birth, adoption or placement for adoption and requests enrollment no later than thirty-one days after becoming a dependent.

16. "Lower level of coverage" means a health benefits plan offered by an accountable health plan for which the actuarial value of the benefits under the health benefits plan is at least eighty-five per cent but not more than one hundred per cent of the policy form weighted average.

17. "Network plan" means a health benefits plan provided by an accountable health plan under which the financing and delivery of health benefits are provided, in whole or in part, through a defined set of providers under contract with the accountable health plan in accordance with the determination made by the director pursuant to section 20-1053 regarding the geographic or service area in which an accountable health plan may operate.

18. "Policy form weighted average" means the average actuarial value of the benefits provided by all health benefits plans issued by either the accountable health plan or, if the data are available, by all accountable health plans in the group market in this state during the previous calendar year, weighted by the enrollment for all coverage forms.

19. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefits plan issued by an accountable health plan. A genetic condition is not a preexisting condition in the absence of a diagnosis of the condition related to the genetic

information and shall not result in a preexisting condition limitation or preexisting condition exclusion.

20. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health benefits plan offered by an accountable health plan.

21. "Small employer" means an employer who employs at least two but not more than fifty eligible employees on a typical business day during any one calendar year. As used in this paragraph, "employee" shall include the employees of the employer and the individual proprietor or self-employed person if the employer is an individual proprietor or self-employed person.

22. "Taft-Hartley trust" means a jointly-managed trust, as allowed by 29 United States Code sections 141 through 187, that contains a plan of benefits for employees and that is negotiated in a collective bargaining agreement governing the wages, hours and working conditions of the employees, as allowed by 29 United States Code section 157.

23. "Waiting period" means the period that must pass before a potential participant or beneficiary in a health benefits plan offered by an accountable health plan is eligible to be covered for benefits as determined by the individual's employer.

B. Coverage for a late enrollee begins on the date the person becomes a dependent if a request for enrollment is received within thirty-one days after the person becomes a dependent.

Sec. 5. Section 20-2304, Arizona Revised Statutes, is amended to read:

20-2304. Availability of insurance; premium tax exemption

A. ~~Beginning on July 1, 1997,~~ As a condition of doing business in this state, each accountable health plan shall offer at least one health benefits plan on a guaranteed issuance basis to small employers as required by this section. All small employers qualify for this guaranteed offer of coverage. The accountable health plan shall provide a health benefits plan to each small employer without regard to health status-related factors if the small employer agrees to make the premium payments and to satisfy any other reasonable provisions of the plan that are not inconsistent with this chapter.

B. If an accountable health plan offers more than one health benefits plan to small employers, the accountable health plan shall offer a choice of all health benefits plans that the accountable health plan offers to small employers and shall accept any small employer that applies for any of those plans.

C. In addition to the requirements prescribed in section 20-2323, for any offering of any health benefits plan to a small employer, as part of the accountable health plan's solicitation and sales materials, an accountable health plan shall make a reasonable disclosure to the employer of the availability of the information described in this subsection and, on request of the employer, shall provide that information to the employer. The accountable health plan shall provide information concerning the following:

1. Provisions of coverage relating to the following, if applicable:

(a) The accountable health plan's right to change premium rates and the factors that may affect changes in premium rates.

(b) Renewability of coverage.

(c) Any preexisting condition exclusion.

(d) Any affiliation period applied by a health care services organization.

(e) The geographic areas served by health care services organizations.

2. The benefits and premiums available under all health benefits plans for which the employer is qualified.

D. The accountable health plan shall describe the information required by subsection C of this section in language that is understandable by the average small employer and with a level of detail that is sufficient to reasonably inform a small employer of the employer's rights and obligations under the health benefits plan. This requirement is satisfied if the accountable health plan provides each of the following for each product the accountable health plan offers:

1. An outline of coverage that describes the benefits in summary form.

2. The rate or rating schedule that applies to the product, preexisting condition exclusion or affiliation period.

3. The minimum employer contribution and group participation rules that apply to any particular type of coverage.

4. In the case of a network plan, a map or listing of the areas served.

E. An accountable health plan is not required to disclose any information that is proprietary and protected trade secret information under applicable law.

F. An accountable health plan that issues a health benefits plan through a network plan may limit the employers that may apply for any health benefits plan offered by the accountable health plan to those eligible individuals who live, work~~,~~ or reside in the service area for the network plan of the accountable health plan.

G. On approval of the director, an accountable health plan may refuse to enroll a qualified small employer in a health benefits plan or in a geographic area served by the plan if the accountable health plan demonstrates that its financial or administrative capacity to serve previously enrolled groups and individuals would be impaired. An accountable health plan that refuses to enroll a qualified small employer may not enroll an employer of the same or larger size until the earlier of:

1. The date on which the director determines that the accountable health plan has the capacity to enroll a qualified small employer.

2. The date on which the accountable health plan enrolls a qualified small employer.

H. An accountable health plan that offers coverage to a qualified small employer shall offer coverage to all of the eligible employees of the qualified small employer and their eligible dependents.

I. An accountable health plan may request health screening and underwriting information on prospective enrollees to evaluate the risks associated with a qualified small employer who applies for coverage. The accountable health plan may use this information for the purposes of setting premiums, evaluating plan offerings and making reinsurance decisions. An accountable health plan shall not use this information to deny coverage to a qualified small employer or to an eligible employee or to an eligible dependent, except a late enrollee who attempts to enroll outside an open enrollment period.

J. ~~Notwithstanding the requirements of section 20-224, subsection B and sections 20-837, 20-1010 and 20-1060, beginning July 1, 1996, accountable health plans shall pay a premium tax of one per cent of the net premiums received for health benefits plans issued to small employers. Beginning July 1, 1997,~~ Accountable health plans are exempt from the premium taxes that are required by this subsection, section 20-224, subsection B and sections 20-837, 20-1010 and 20-1060~~,~~ for the net premiums received for health benefits plans issued to small employers, INCLUDING THE NET PREMIUMS COLLECTED FROM COVERAGE ISSUED PURSUANT TO SECTION 20-2313, SUBSECTION C. Each accountable health plan shall notify the small employers to whom it provides coverage of the reductions in the premium tax as specified in this subsection.

K. The director may use independent contractor examiners pursuant to sections 20-148 and 20-159 to review the higher level of coverage and lower level of coverage health benefits plans offered by an accountable health plan insurer in compliance with this section. All examination and examination related expenses shall be borne by the insurer and shall be paid by the insurance examiners' revolving fund pursuant to section 20-159.

Sec. 6. Section 20-2309, Arizona Revised Statutes, is amended to read:

20-2309. Renewability

A. At least sixty days before the date of expiration of a health benefits plan, an accountable health plan that provides a health benefits plan shall provide for written notice to the employer of the terms for renewal of the plan. The notice shall include an explanation of the extent to which any increase in premiums is due to actual or expected claims experience of the individuals covered under the employer's health benefits plan contract.

B. An accountable health plan may refuse to renew or may terminate a health benefits plan only if:

1. The employer fails to pay premiums or contributions in accordance with the terms of the health benefits plan of the accountable health plan or the accountable health plan does not receive premium payments in a timely manner.

2. The employer committed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the health benefits plan.

3. The employer has failed to comply with a material plan provision relating to individual or employer participation rules as prescribed in subsection C of this section.

4. The accountable health plan has ceased to offer NEW coverage AND HAS TERMINATED OR CEASED TO RENEW ALL IN-FORCE COVERAGE in the group market pursuant to this section.

5. In the case of an accountable health plan that offers a health benefits plan through a network plan in this state, there is no longer any enrollee in connection with the accountable health plan who lives, resides or works in the service area of the accountable health plan or in the area served by the network plan for which the accountable health plan is authorized to do business and the accountable health plan would deny enrollment pursuant to section 20-2304, subsection G.

6. In the case of an accountable health plan that offers a health benefits plan in the group market only through one or more bona fide associations, the membership of an employer in the association has ceased but only if that coverage is terminated uniformly without regard to any health status-related factor or any covered individual.

C. An accountable health plan may require that a minimum percentage of employees who are not covered under a spouse's or parent's employer's health benefits plan be enrolled in a plan if the percentage is applied uniformly to all plans that are offered to employers of comparable size.

D. An accountable health plan is not required to renew a health benefits plan with respect to an employer or individual if the accountable health plan:

1. Elects not to renew all of its health benefits plans that are issued to employers or individuals in this state.

2. Provides notice to the director at least five business days before the accountable health plan gives notice to each employer or individual covered under a health benefits plan of the intention to discontinue offering any health benefits plans in this state.

3. Provides notice of termination OR NONRENEWAL to each employer or individual covered under a plan at least one hundred eighty days before the ~~expiration~~ RENEWAL date of the plan. If the accountable health plan terminates coverage, the accountable health plan may not issue a health benefits plan to an employer in this state during the five year period beginning on the termination date of the last plan that was not renewed.

E. If an accountable health plan decides to discontinue offering a particular health benefits plan offered in the group market, the accountable health plan may discontinue that coverage only if the accountable health plan:

1. Provides notice to the director at least five business days before the accountable health plan gives notice to each employer or individual covered under that health benefits plan of the intention to discontinue offering that health benefits plan in this state.

2. Provides notice to each employer or individual covered under that health benefits plan at least ninety days before the date of the discontinuation of that coverage.

3. Offers to each employer whose coverage is discontinued pursuant to this subsection the option to purchase all other health benefits plans currently offered by the accountable health plan for employers in the group market uniformly without regard to any health status-related factor of any employee or a spouse or a dependent of the employee enrolled or individuals who may become eligible for that coverage.